King County

Department of Community and Human Services

Data Report on Equity and Social Justice Commitment Outcomes

December 2009

Acknowledgements

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I. Introduction

In February 2008, the Department of Community and Human Services (DCHS) made commitments to review and analyze access to homelessness, mental health, substance abuse and birth to three early intervention services for certain racial, ethnic and low-income populations in King County. The DCHS further refined these commitments and the resulting access or utilization of services report was published in April 2009.

This document is the required year-end 2009 follow up report on the department's commitments, providing data and analysis on the outcomes for these services for the specified populations. In each commitment section, the report also presents an update on the information provided in the April 2009 report concerning access to services by minority groups. Each discussion also provides recommendations for future Equity and Social Justice (ESJI) related efforts.

The analyses presented here rely upon data collected from internal DCHS databases, as well as external sources such as the Washington State Infant Toddler Early Intervention Program, TARGET system, and Safe Harbors Homeless Management Information System (HMIS). In some, but not all cases, the data available was rich enough to allow statistical analysis techniques to be used; in the rest, numbers served and percentages of total served were provided. For commitments I and II, data trends from 2004 to 2008 were analyzed. For Commitment III, 2008 data was used from the new Safe Harbors HMIS.

Section II provides access information, data and outcome analysis for Commitment I on mental health and substance abuse services. In this section, the populations discussed are Medicaid eligible individuals, typically below the federal poverty level. Section III provides access information, data and outcome analysis for Commitment II on prevention and early intervention services for all children in King County, regardless of family income, ranging in age from birth to three years old. Section IV provides access information, data and a system-wide discussion on outcome analysis for Commitment III on homelessness prevention. This section analyzes data compared to county populations living below the federal poverty level, as these are the individuals most likely to be homeless or at risk of homelessness. Section V contains a discussion on overall conclusions and recommendations regarding outcomes for the targeted populations, for all three commitments.

II. Commitment I: Mental Health and Substance Abuse

The 2008 DCHS ESJI Commitment on Mental Health and Substance Abuse reads as follows:

DCHS will increase its knowledge and understanding of disproportionate access to mental health and substance abuse services through better identification of affected populations, measurement of appropriate levels of service, and determination of whether outcomes are equally effective across population groups.

This section provides an update regarding the utilization by Medicaid eligible population groups of the county's mental health and substance abuse services. Data is provided from King County mental health, Washington State Division of Alcohol and Substance Abuse and other information systems. As stated in the April 2009 report's action plan, all Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) program results are summarized, with a special focus on outcomes for chemical dependency services.

Summary

For the April 2009 report, MHCADSD assessed representation of different racial and ethnic groups receiving mental health and substance abuse treatment, compared to each groups' prevalence of those living in the county whose incomes were under the federal poverty level (FPL). These low-income groups are the most likely to be eligible for Medicaid funded services, which the county provides. The time period looked at was 2004 - 2007. For this report, MHCADSD looked at the same figures for those in treatment for 2008.

For both mental health and chemical dependency treatment, the parity numbers representing who is receiving services compared to the population below FPL have remained stable. This is not surprising, as interventions in the division have focused on improving outcomes of treatment, and not on getting more people of a particular racial or ethnic group to access service. Table 1 below shows that access to service is at parity for most groups, compared to their representation in the population below FPL. Notable exceptions to this are Native Americans, who access outpatient substance abuse treatment services at a rate two-and-a-half times their presence in this population; Hispanics, who access both mental health and outpatient substance abuse treatment at roughly 70 percent of their population (with the exception of older Hispanics[1], who access mental health services at two-and-a-half times their

[1] Older Hispanics are those age 65 and over.

population rate and substance abuse treatment services at three times their population rate); and Asian/Pacific Islanders, who access mental health services at about half of their population rate and substance abuse treatment services at about one-third their population.

Table 1. Summary of Populations Served by Ethnic/Racial Groups

Reported Race or Ethnicity	2005 - 2007 King County Population Estimate				Percentage of All People Served in 2008 in Substance Abuse or Mental Health			
	Number		% of Total		Mental Health	Substance Abuse		
	All	<FPL	All	<FPL		Any	OP	OST
White Alone	1,324,011	100,518	73	**57**	58	58	52	75
AA Alone	103,830	29,103	6	**16**	18	20	22	12
NA Alone	13,109	3,318	0.7	**1.9**	2.3	4.5	4.7	3.0
API Alone	246,132	24,399	14	**14**	7	5	6	2
Other Alone	55,142	10,203	3	**6**	*8*	*10*	*11*	*5*
Two or more	64,575	9,604	4	**5**	6	4	5	2
Total	**1,806,799**	**177,145**	**100**	**100**	**100**	**100**	**100**	**100**
Hispanic	128,940	24,235	7	**14**	10	10	11	5

OP - outpatient chemical dependency treatment
OST - opiate substitution treatment

AA - African American
NA - Native American
API - Asian or Pacific Islander

Percentages for "NA (Native American) Alone" are displayed to one decimal so that comparisons are more meaningful, given the small numbers.
Percentages for "Other (race) Alone" of "People Served" are italicized because they include "Unknown". This makes comparison to the population percentage not meaningful.

A more detailed analysis by age, as well as race/ethnicity, is shown in Table 2, following page. This table contains “parity” statistics that compare the percentage for the service group to the percentage for the “below poverty level” (<FPL) group. These make it easier to see the size of differences between percentages; this is especially important because most of the percentages, as shown, are rounded to whole numbers which can hide meaningful differences.

A parity figure of 1.00 indicates that the group is served equally to its proportion in the low income population; figures below 1.00 indicate it is served below its proportion, and above 1.00 indicate that a higher percentage of people from the race or ethnic group are served than are found in the low income population. Note the <FPL column highlighted in green on the left, and compare it to the <FPL column highlighted in red on the right of the parity table.

Table 2. Comparison of KC Population to Recipients of Mental Health and Substance Abuse Services

Reported Race or Ethnicity	2005 - 2007 King County Population Estimate				People Served, 2008								Parity (% of pop or service group compared to "% <FPL")					
	Number		% of Total		Mental Health Services		Substance Abuse Services						King County		MH	SA Service		
							Any		Outpatient		Opiate Sub Tx							
	All	<FPL	All	<FPL	#	%	#	%	#	%	#	%	All	<FPL	Serv	Any	OP	OST
All Ages																		
White Alone	1,324,011	100,518	73	57	20,007	58	7,827	58	4,959	52	2,180	75	1.29	**1.00**	1.02	1.02	0.92	1.33
AA Alone	103,830	29,103	6	16	6,228	18	2,661	20	2,115	22	355	12	0.35	**1.00**	1.10	1.19	1.35	0.75
NA Alone	13,109	3,318	1	2	780	2	612	5	452	5	87	3	0.39	**1.00**	1.21	2.41	2.53	1.60
API Alone	246,132	24,399	14	14	2,565	7	620	5	542	6	64	2	0.99	**1.00**	0.54	0.33	0.41	0.16
Other Alone	55,142	10,203	3	6	*2,810*	*8*	*1,327*	*10*	*1,051*	*11*	*152*	*5*	0.53	**1.00**	*1.41*	*1.70*	*1.91*	*0.91*
Two or more	64,575	9,604	4	5	2,146	6	522	4	430	5	59	2	0.66	**1.00**	1.15	0.71	0.83	0.38
Total	**1,806,799**	**177,145**	**100**	**100**	**34,536**	**100**	**13,569**	**100**	**9,549**	**100**	**2,897**	**100**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Hispanic	128,940	24,235	7	14	3,553	10	1,304	10	1,076	11	154	5	0.52	**1.00**	0.75	0.70	0.82	0.39
Children/Youth	(<18)				(<18)		(<18)											
White Alone	257,520	18,787	66	40	3,698	45	601	46	601	46			1.64	**1.00**	1.12	1.14	1.14	
AA Alone	30,291	12,448	8	27	1,643	20	216	16	216	16			0.29	**1.00**	0.75	0.62	0.62	
NA Alone	2,924	1,114	1	2	209	3	42	3	42	3			0.31	**1.00**	1.07	1.35	1.35	
API Alone	52,814	5,318	13	11	501	6	84	6	84	6			1.19	**1.00**	0.54	0.56	0.56	
Other Alone	17,748	4,928	5	11	*1,034*	*13*	*258*	*20*	*258*	*20*			0.43	**1.00**	*1.19*	*1.87*	*1.87*	
Two or more	30,715	4,315	8	9	1,172	14	112	9	111	8			0.85	**1.00**	1.54	0.93	0.92	
Total	**392,012**	**46,910**	**100**	**100**	**8,257**	**100**	**1,313**	**100**	**1,312**	**100**			**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	
Hispanic	43,253	10,567	11	23	1,592	19	289	22	288	22			0.49	**1.00**	0.86	0.98	0.97	
Adults	(18-64)				(18-59)		(18-59)		(18+)									
White Alone	911,731	69,849	74	62	13,027	61	7,075	59	4,358	53	2,180	75	1.20	**1.00**	0.99	0.96	0.84	1.20
AA Alone	66,587	15,201	5	13	4,158	19	2,387	20	1,899	23	355	12	0.40	**1.00**	1.45	1.48	1.80	0.96
NA Alone	9,324	2,035	1	2	521	2	552	5	410	5	87	3	0.42	**1.00**	1.36	2.56	2.94	1.77
API Alone	171,211	15,555	14	14	1,327	6	513	4	458	6	64	2	1.01	**1.00**	0.45	0.31	0.38	0.15
Other Alone	36,297	5,184	3	5	*1,362*	*6*	*1,046*	*9*	*793*	*10*	*152*	*5*	0.64	**1.00**	*1.39*	*1.90*	*2.38*	*1.30*
Two or more	32,041	5,113	3	5	943	4	405	3	319	4	59	2	0.58	**1.00**	0.98	0.75	0.95	0.50
Total	**1,227,191**	**112,937**	**100**	**100**	**21,338**	**100**	**11,978**	**100**	**8,237**	**100**	**2,897**	**100**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Hispanic	81,718	13,335	7	12	1,717	8	999	8	788	10	154	5	0.56	**1.00**	0.68	0.71	0.91	0.51
Older Adults	(>64)				(>59)		(>59)											
White Alone	154,760	11,882	82	69	3,282	66	151	54					1.20	**1.00**	0.97	0.79		
AA Alone	6,952	1,454	4	8.4	427	8.6	58	21					0.44	**1.00**	1.03	2.48		
NA Alone	861	169	0	1	50	1	18	6					0.47	**1.00**	1.04	6.63		
API Alone	22,107	3,526	12	20	737	15	23	8					0.58	**1.00**	0.73	0.41		
Other Alone	1,097	91	1	1	*414*	*8*	*23*	*8*					1.11	**1.00**	*15.93*	*15.73*		
Two or more	1,819	176	1	1	31	1	5	2					0.95	**1.00**	0.62	1.77		
Total	**187,596**	**17,298**	**100**	**100**	**4,941**	**100**	**278**	**100**					**1.00**	**1.00**	**1.00**	**1.00**		
Hispanic	3,969	333	2	2	244	5	16	6					1.10	**1.00**	2.57	2.99		
"Parity" calculation:			**a**	**x**		**b**		**c**		**d**		**e**	**=a/x**	**=x/x**	**=b/x**	**=c/x**	**=d/x**	**=e/x**

Although figures indicating under representation of Asian/Pacific Islander populations are troubling, there are limitations on this report's ability to address some of the underlying contributing factors to this disparity. This under representation in behavioral health services is consistent with national trends. It is important to note that 43 different ethnic groups, with their own cultures and multiple languages, comprise this category, so teasing out differences for culturally specific interventions may be difficult. This is the one population that contains more immigrants than U.S. born members.

Contributing factors to under utilization of mental health and drug treatment services include the following[2]:

- High stigmatization of mental illness, leading to reluctance on the part of individuals to be served by culturally homogeneous providers for fear of being "identified" in their community
- Shortage of trained providers with appropriate linguistic ability and cultural understanding
- Perceived culture gap between Asian/Pacific Islanders and non Asian/Pacific Islander providers
- Lack of mind and body as separate concepts in the culture. Mental illness as a separate construct does not exist for some individuals. Asian culture typically does not conceptualize people as divided into mind and body, but rather sees the mind and body as a single unified system; therefore mental illness may not be seen as a condition separate from physical illness[2]
- Most of the funding for mental health and substance abuse treatment comes from Medicaid, and very little funding is available for individuals who are not eligible for Medicaid. Many of the individuals in the Hispanic and Asian/Pacific Islander communities who are in need of publicly funded treatment are not eligible for Medicaid due to their immigrant status. A huge proportion of MHCADSD non-Medicaid funds are directed for these communities, and there are no more funds available

The MHCADSD is supporting access to services for both Asian/Pacific Islanders and Hispanics. The division's goals are to assure that there are appropriate resources in the community for members of these populations who need services, that MHCADSD is retaining individuals in treatment, and that individuals experience improved outcomes in their lives as a result of their engagement in services.

[2]This understanding often leads individuals from many of these cultures to experience a mental state, such as depression or anxiety, as physical symptoms, such as sleep disturbance, gastro-intestinal disorders, pain, etc., and to seek treatment form medical, rather than mental health, providers.

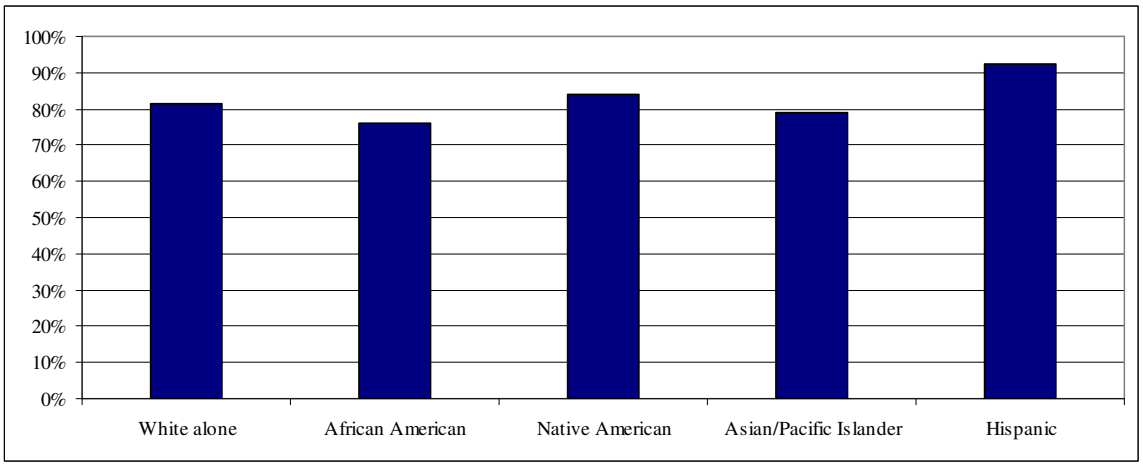
Mental Health Outcomes

This year, MHCADSD took an initial look at those who are receiving mental health services to see if there were any significant differences in outcome by racial or ethnic group. Goals of both mental health and substance abuse treatment include symptom reduction, stabilization of living situation, and reductions in use of high cost services, such as jails and emergency rooms.

Employment

Individuals who were unemployed at the start of their mental health benefit had nearly equally poor results gaining employment by the end of 2008. Success for African Americans, Native Americans and Hispanics were from 2.3, 2.6 and 2.8 percent respectively and for Whites and Asian/Pacific Islanders the rates were 3 and 3.5 percent respectively. For those who were employed at the start of the benefit, rates of retaining employment were comparatively high across groups. African Americans had the lowest retention rate, at 76 percent and Hispanics had, by far, the highest, at 92 percent. The graph below illustrates the employment gains discussed.

Chart 1. Adults who Remained Employed by Race/Ethnicity



Housing and Homelessness

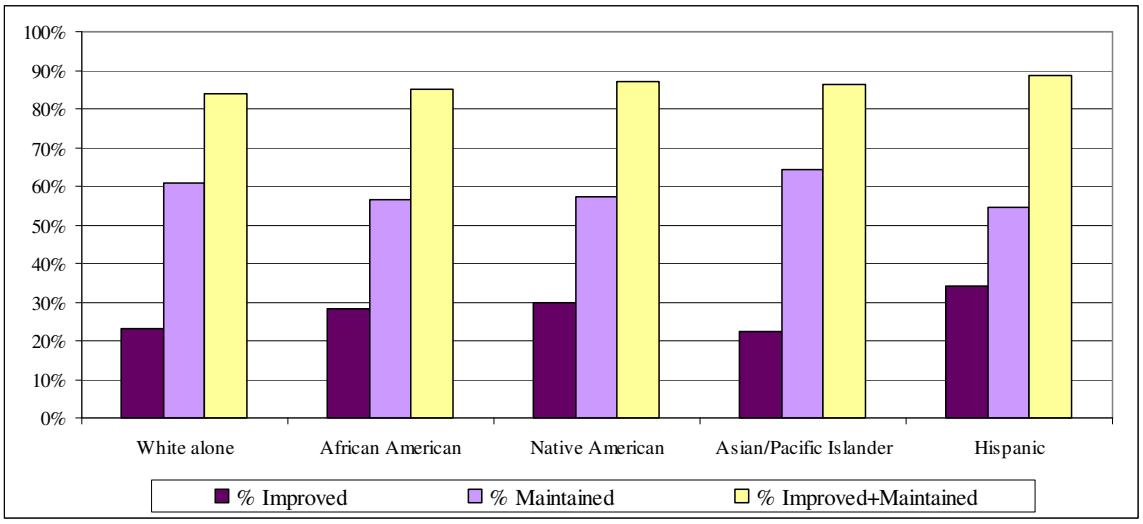
Virtually all individuals across racial and ethnic groups who were housed at the beginning of their mental health benefits maintained that housing throughout their benefit period. Of those who were homeless at the start, about 30 percent were able to obtain housing across ethnic groups, with the exception of Hispanics, whose housing acquisition rate was closer to 20 percent.

Maintenance and Improvement in Functioning

Maintenance and improvement of functioning combined was comparable across racial and ethnic groups, ranging from 84 - 89 percent. There were slight variations in improvement, with Asian/Pacific Islanders reporting the lowest improvement rates (23

percent) and Hispanics demonstrating greatest improvement (34 percent), as shown in the following chart.

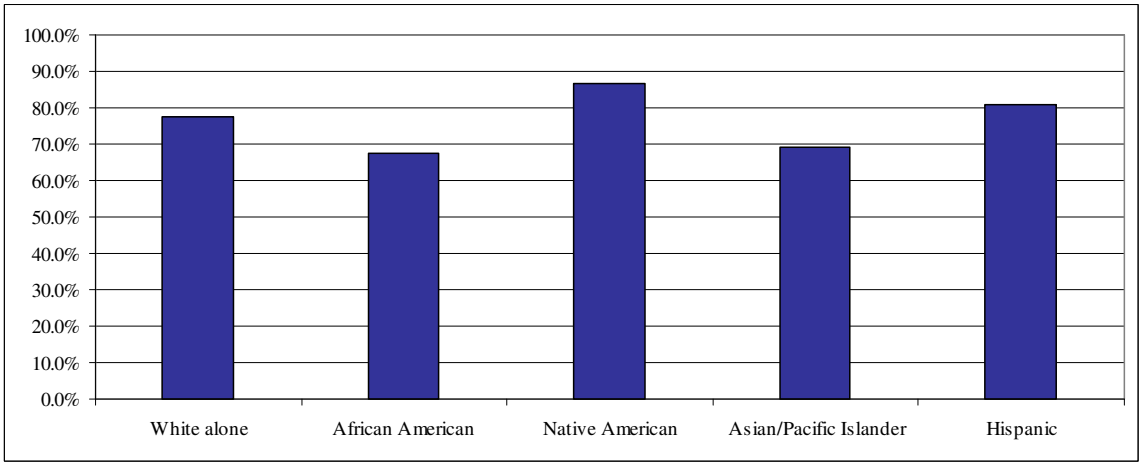
Chart 2. Maintained or Improved Level of Functioning



Incarceration Reduction

Looking at reductions in incarcerations, there were comparable reductions among youth from all ethnic groups (about 60 percent, although the numbers served are too small to be meaningful, i.e. 30 or less for each group). There were impressive reductions in adult incarcerations across all racial and ethnic groups, from a low of 67.5 percent for African Americans to a high of 86.8 percent for Native Americans. Numbers for Native Americans, Hispanics, and Asian/Pacific Islanders were quite small, less than 50 for each group, but were consistent with the overall trend. Chart 3 below illustrates these reductions.

Chart 3. Adults who Reduced Incarceration



The MHCADSD committed to analyzing 2008 chemical dependency completion and retention rates by race/ethnicity and age for this year's report.

The following section focuses on that commitment, in order to identify variances in treatment completion and retention. The ultimate goal is to assure that outcomes are equally effective across population groups. In the future, it may be helpful to explore other defining population characteristics, such as sexual orientation, linguistic capacity, or co-occurring morbidities that may affect treatment experiences.

Treatment completion and retention rates have improved across all racial and ethnic groups from 2004 through 2008. Although treatment completion and retention for the adult and youth African American and Native American groups have historically been lower than other groups, outcomes improved for adults and youth in both of these groups from 2004 to 2008. Treatment retention improvements were generally comparable across all groups, with Native American adults showing the largest increase.

However, the greatest improvements were seen among treatment completion rates for African Americans. Treatment completion rates increased by more than 90 percent for adults and by approximately 125 percent for youth in this group.

In 2009, MHCADSD analyzed treatment completion and treatment retention rates for adults (age 24 or older) and youth (under age 24) who were admitted to outpatient substance treatment to identify differences across ethnic groups. The 2009 analysis did not include gender or provider as factors. Because there have been targeted efforts in recent years to improve treatment completion and retention for youth of color (the Seattle Youth Enhancement Project) and for the Native American adult population, the analysis compared data for each year from 2004 through 2008 to include changes in those outcomes from recent efforts. This analysis used substance abuse treatment data reported by all providers to the state TARGET system.

Rather than looking only at those who have completed treatment, the analysis looks at all of those who entered treatment during the time period reviewed. Thus, the data for the most recent year (2008) includes significantly more admissions who had not yet reached their expected completion date at the time of this analysis. Those who were still in treatment and expected to be in treatment at the time of this analysis were combined with those who had successfully completed treatment to measure "treatment completion" outcomes. Treatment completion is therefore defined as those who had completed their course of prescribed treatment with a successful program discharge or who had not yet reached their completion dates and were currently engaged in care at the time of the data analysis, regardless of how many days they had been in treatment. Treatment retention is defined as those who were in treatment for at least 90 days, regardless of completion. Research has shown that completing at least 90 days of treatment is strongly associated with better treatment outcomes than for those who do not complete 90 days of treatment.

Four improvements that have been occurring in the treatment environment in King County over the last several years have likely contributed to the increased treatment completion and treatment retention success rates the data are showing. These are:

- More people who are receiving long-term mental health treatment are beginning to receive substance abuse treatment in conjunction with their mental health treatment.
- The treatment system has begun a shift from an acute care model to a chronic care model because research has shown a chronic care model to be more effective for many people with substance abuse/chemical dependency problems.
- Youth completion and retention rates have increased as a result of services delivered under the Reclaiming Futures project, which included the implementation of a standardized assessment and a coordinated client survey.
- The MHCADSD has been providing technical assistance to providers to improve reporting consistency. This assistance was provided in conjunction with increases to King County's targeted treatment completion rate improvements that were negotiated with the state as a part of biennial contracts. These expected rate improvements have been passed on to providers as contract requirements. Improvements in reporting that resulted from this technical assistance may artificially inflate outcomes to some degree when compared to earlier periods.

The focus of the analysis was to identify differences in treatment outcomes across racial and ethnic groups in order to identify opportunities for MHCADSD to improve agency and clinical cultural competence. In so doing, MHCADSD can create positive treatment experiences for all people entering treatment, regardless of race, ethnicity or cultural background.

To examine whether differences in race/ethnicity may be related to treatment outcomes, the following approach was used to identify groups of interest while recognizing that people do not fall neatly into discrete ethnic groups. First, based on self-report, those who received services were identified as either "White Only/Not Hispanic" or "Of Color" (including those who identified as African American, Native American, Asian/Pacific Islander and/or Hispanic). Each admission was counted in only one of these two groups. Then, to analyze differences between the four groups that were combined into "Of Color", each person who identified as belonging to any of those four groups was counted for each of the one or more groups identified. This approach, rather than restricting each of those groups to individuals reporting only a single group, was used in recognition that an individual may be a member of two or more of these groups and that affiliation with each group may be a significant factor in his or her life experience. Because of this approach, the "White Only/Not Hispanic" and "Of Color" groups together comprise all admissions, but within the African American, Native American, Asian/Pacific Islander, and Hispanic groups (each of which is a subset of the "Of Color" group) there is a small percentage of people (larger for youth than adults) who are in two or more of those groups.

Data for admissions to treatment for 2004 through 2008 demonstrated higher rates of treatment completion and retention for adult White populations as compared to all minority groups combined, except for treatment completion in 2007 when both groups had the same rate. Completion rates for youth were higher for White populations for 2004 through 2008. Retention rates for youth are higher for non-White populations combined than for the White population from 2004 to 2008. Completion and retention rates for all populations increased during the 2004 to 2008 period, with the completion rate increasing noticeably from 2007 to 2008.

The following pair of graphs shows the changes in adult treatment completion and adult treatment retention by each of the groupings described above. The data in accompanying tables (Tables 3 and 4) show the number of admissions within each group; those are the denominators for the percentage that are graphed. Those numbers reflect a large increase in the number of adults who were admitted to substance abuse treatment during these years because more funding for treatment became available. So, not only have treatment retention and completion rates improved, but treatment access across groups has increased during this time period as well.

Chart 4. Adults who Completed (or Remain in) Treatment, by Ethnic Group

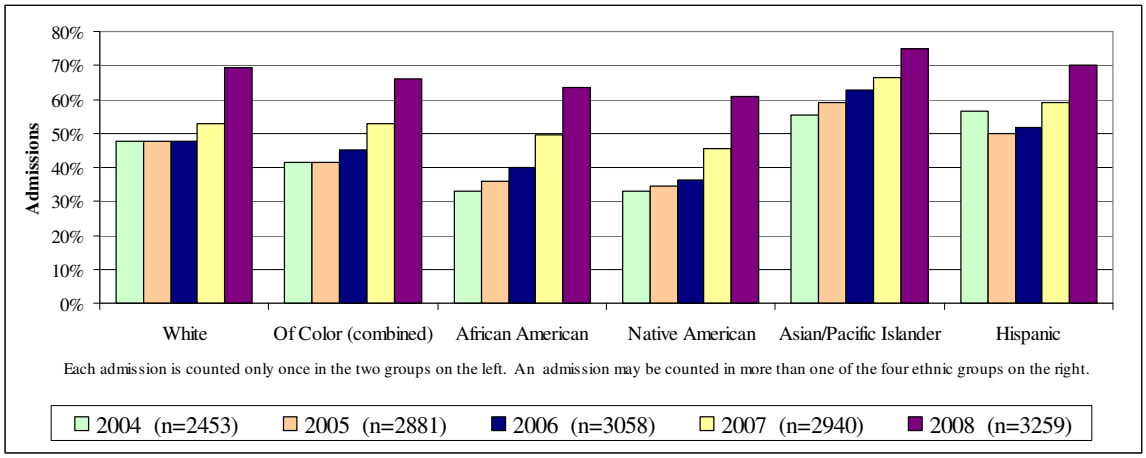


Table 3. Adult Treatment Completion Data

	Admission Year				
Ethnic Group	**2004**	**2005**	**2006**	**2007**	**2008**
White	1,378	1,586	1,714	1,578	1,725
Of Color	1,075	1,295	1,344	1,362	1,534
All Admissions	**2,453**	**2,881**	**3,058**	**2,940**	**3,259**
African American	565	721	734	760	891
Native American	160	232	223	250	223
Asian/Pacific Islander	128	152	161	160	194
Hispanic	251	254	282	270	297

Chart 5. Adults who Remained in Treatment at least 90 Days, by Ethnic Group

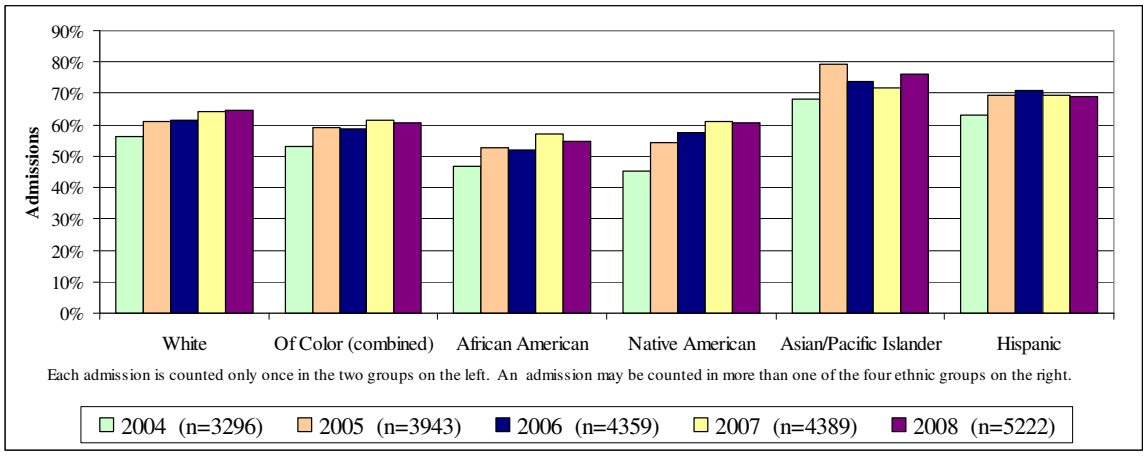


Table 4. Adult Treatment Retention Data

	Admission Year				
Ethnic Group	**2004**	**2005**	**2006**	**2007**	**2008**
White	1,898	2,183	2,384	2,344	2,733
Of Color	1,398	1,760	1,975	2,045	2,489
All Admissions	**3,296**	**3,943**	**4,359**	**4,389**	**5,222**
African American	764	979	1,143	1,193	1,528
Native American	216	319	316	356	352
Asian/Pacific Islander	154	197	222	224	292
Hispanic	307	340	384	392	441

Among adults (age 24 or older), the treatment completion rate for Whites was 48 percent in 2004 and 69 percent in 2008, an overall improvement of 46 percent for this time period. African American, Native American, Asian/Pacific Islander, and/or Hispanic populations had a treatment completion rate of 41 percent in 2004 and 66 percent in 2008, demonstrating a 59 percent increase in retention rate during this period. African American populations had a treatment completion rate of 33 percent in 2004 and 64 percent in 2008, an improvement of 93 percent.

There are notable differences in the results between the African American, Native American, Asian/Pacific Islander and Hispanic adult population. For both treatment completion and treatment retention, the African American and Native American groups generally have lower rates across this time period (2004 - 2008) than the Asian/Pacific Islander and Hispanic groups. Despite having lower treatment completion rates than other groups, the trend toward improvement was better among Native Americans for retention, and better among African Americans for completion. Because of these intergroup differences among the groups that are combined for the Of Color group, it will be more useful to focus on the subgroups and their results than to draw conclusions based on the Of Color group.

Among adults, the treatment retention rate (remaining in treatment longer than 90 days) for Whites was 56 percent in 2004 and 64 percent in 2008. African American, Native American, Asian/Pacific Islander, and/or Hispanic populations had a treatment retention rate of 53 percent in 2004 and 60 percent in 2008. The Native American population had a retention rate of 45 percent in 2004 and 61 percent in 2008.

The following charts show the changes in youth treatment completion and youth treatment retention by each of the groupings described above. The accompanying data tables (Tables 5 and 6) show the number of admissions within each group; these are the denominators for the percentages that are graphed. The admission numbers reflect a decline from 2004 to 2006 and an increase from 2006 to 2008 in the number of youth who were admitted to substance abuse treatment during these years. The decline occurred because of several factors despite the availability of more funding for treatment. Among those factors were inadequate reimbursement rates, reductions in the funding that supports school prevention/intervention specialists, and a shortage of qualified youth Chemical Dependency Counselors. Working with providers, schools and the state, MHCADSD implemented several strategies to improve referral networks, review school drug and alcohol policies, address the shortage of qualified treatment staff, and increase vendor rates. The increase since 2006 followed these targeted efforts.

Chart 6. Youth who Completed (or Remain in) Treatment, by Ethnic Group

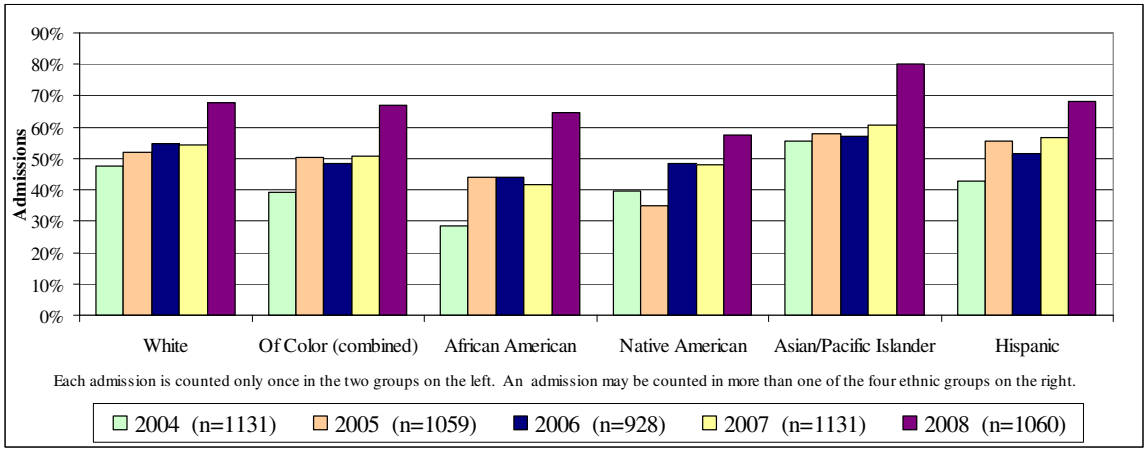


Table 5. Youth Treatment Completion Data

Ethnic Group	Admission Year 2004	2005	2006	2007	2008
White	609	571	495	588	527
Of Color	522	488	433	543	533
All Admissions	**1,131**	**1,059**	**928**	**1,131**	**1,060**
African American	210	194	173	208	212
Native American	48	60	56	73	73
Asian/Pacific Islander	110	102	77	94	90
Hispanic	187	168	159	197	192

Chart 7. Youth who Remained in Treatment at least 90 Days, by Ethnic Group

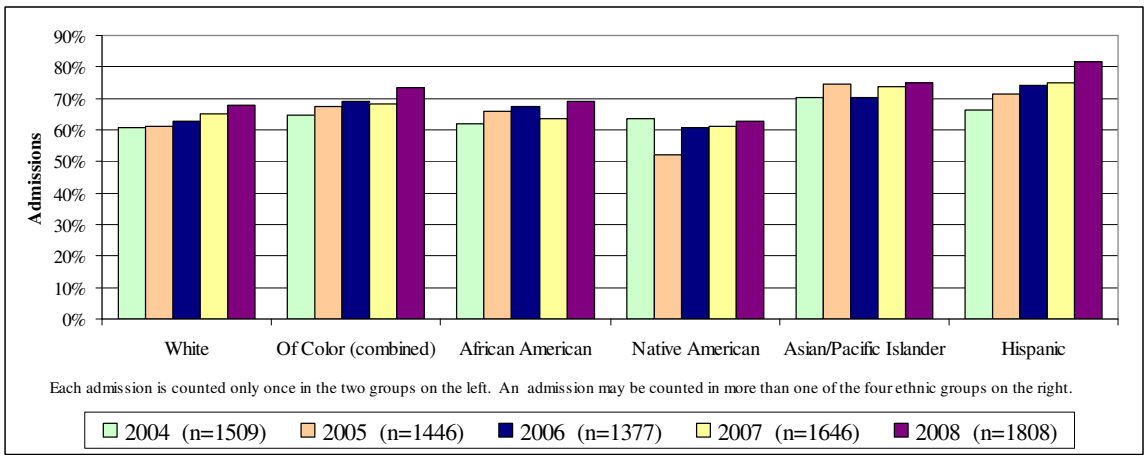


Table 6. Youth Treatment Retention Data

Ethnic Group	Admission Year 2004	2005	2006	2007	2008
White	858	777	697	852	891
Of Color	651	669	680	794	917
All Admissions	**1,509**	**1,446**	**1,377**	**1,646**	**1,808**
African American	274	294	313	341	404
Native American	66	88	97	116	132
Asian/Pacific Islander	131	129	108	119	135
Hispanic	220	209	214	262	310

Among youth (age 23 or younger), the treatment completion rate for Whites was 48 percent in 2004 and 68 percent in 2008, showing a 43 percent improvement. African American, Native American, Asian/Pacific Islander, and/or Hispanic populations had a combined treatment completion rate of 39 percent in 2004 and 67 percent in 2008, a 72 percent overall improvement in completion. Much of this boost was due to the improvement in completion rates for African American populations, who went from a

treatment completion rate of 29 percent in 2004 to 65 percent in 2008, an improvement rate of 126 percent.

There are notable differences in the results between the African American, Native American, Asian/Pacific Islander and Hispanic youth populations for treatment completion before 2008. The African American and Native American groups generally had lower completion rates than the Asian/Pacific Islander and Hispanic groups. In 2008, the rates for African American youth (65 percent), Hispanic youth (68 percent) and White youth (69 percent) are almost equal. The 2008 rates for those three groups are well below Asian/Pacific Islander youth (80 percent) and well above the rate for Native American youth (58 percent).

The previous analysis of data about rates at which different population groups are accessing mental health and substance abuse services (April 2009 Report on DCHS ESJI Commitments) indicated that Native American adults are accessing publicly funded outpatient substance abuse services in King County at a rate three times their percentage in the low-income population. This suggests that access to treatment is not a problem for this group. However, the lower treatment completion and retention rates seen in the data above, and the very high percentage of Native Americans among all users and among the most frequent users of the sobering services provided by the Dutch Shisler Sobering Support Center (DSSSC) indicate significant unmet needs within this group for treatment and supports that promote sustained recovery.

Building on an initiative begun several years ago to improve treatment outcomes for frequent users of the DSSSC, in 2009, MHCADSD began funding a case manager from the Seattle Indian Health Board to perform outreach and engagement with Native Americans at DSSSC and the Chief Seattle Club, in order to help individuals make connections with culturally appropriate treatment services. In the first three months of this position, which is funded by the Mental Illness and Drug Dependency Action Plan, the case manager has assisted more than 25 Native Americans with accessing treatment services.

Recommendations

Our data shows improvements for successful program outcomes. The MHCADSD will therefore continue program efforts with the following refinements.

1. Regularly monitor discharge data reporting from all substance abuse providers. Provide timely additional training as necessary to ensure consistent understanding and reporting of discharge reasons across providers so that future comparisons of treatment completion rates across population groups are not confounded by changes in provider reporting practices.
2. Analyze data from 2008 adult admissions for differences among providers for the following population groups: African American, Native American, Asian/Pacific Islander and Hispanic. Because a few providers with particular cultural expertise serve a large percentage of each of these groups, it may be fruitful to focus on a

comparison of the outcomes for these providers to outcomes for all other providers in the system.

3. Refine the treatment completion and treatment retention measures to apply them appropriately to people with significantly different needs. People who are dually diagnosed with major mental illness or with a developmental delay in addition to substance abuse or dependence may be better served when they continue to receive substance abuse treatment for years. For this group, treatment completion is not a useful outcome measure, and a treatment retention measure that counts success as remaining in treatment for 90 days or more may be too short-term.

Looking to the Future

Now that MHCADSD has a better sense of what the data show, both access and outcome data will be shared with the chemical dependency and mental health treatment providers. The division will get their input on what, if anything, they believe should be done to address any areas where there are disparities. Based on this feedback, and further analysis within the division, MHCADSD will develop a plan of action. The division will incorporate elements of this action plan into locally developed trainings as they are rolled out to chemical dependency providers and then expand them to the mental health providers.

A second area of ESJI focus will dovetail one of the division's performance improvement projects that is already on going within the mental health service area. Individuals with severe mental health issues who have to be maintained on "atypical" antipsychotic agents often wind up with metabolic syndromes that increase morbidity and significantly shorten their life spans. The MHCADSD is currently working with contracted mental health providers to develop health interventions and/or stronger linkages to primary care to address these syndromes. The division will add a racial/ethnic focus, as it is known that some racial groups, such as African Americans, tend to be more prone to these metabolic complications.

As programs funded through special initiatives such as the Veterans and Human Services Levy, the Mental Illness and Drug Dependency Action Plan, the Criminal Justice Initiatives and the Committee to End Homelessness' Ten-Year Plan mature and impact on outcomes, MHCADSD staff are working closely with other divisions to assure evaluation efforts are as coordinated and efficient as possible.

III. Commitment II: Prevention and Early Intervention

The 2008 DCHS ESJI Commitment on Prevention and Early Intervention reads as follows:

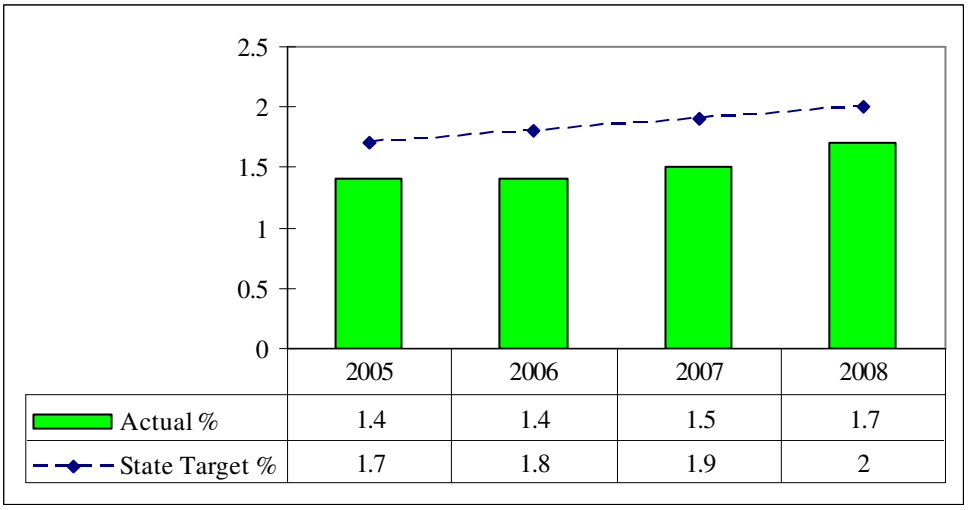
Prevention and Early Intervention: With its partners, the Department of Community and Human Services will review its services for inequities related to prevention and early intervention for the population birth to age three and, where they exist, craft and implement mitigation strategies.

Summary

Because King County receives federal funds for serving children birth to age three, the Developmental Disabilities Division (DDD) is required to meet certain outcomes regarding its Early Intervention (EI) program, one of which is to serve a percentage of the total birth to three population in the county. Washington State has set this target percentage annually; it currently stands at 2.2 percent.

The DDD has an overall business plan performance measure tracking the annual percentage of children within the county to access EI services, against the state established target. The chart which follows shows a view of historical achievements against that target.

Chart 8. Percent of All Birth to Three Children Accessing Early Intervention Services



	2005	2006	2007	2008
Actual %	1.4	1.4	1.5	1.7
State Target %	1.7	1.8	1.9	2

The best measure for DDD is data from the Infant Toddler Early Intervention Program (ITEIP) for federal counts. The DDD eligibility criteria and enrollment procedures ensure equitable access to services for all children in King County. All children in services, regardless of economic status, are captured in DDD data.[3]

Demographic and Parity Analysis for Access to Services

Looking at the 2008 end of year data on children who are accessing EI services, DDD has several findings. Table 7 following provides a summary of children served, broken out by race/ethnicity. This is an update to the access data in the April 2009 report.

[3] In federal fiscal year 2007, Washington state reported 1.82% of children 0-3 with early intervention services, ranking 20th in comparison to 25 states and territories with similar early intervention eligibility criteria. Despite increased emphasis on services to the very young (0-12 months), the state had .53% of these children in services, and ranked 22nd among the 24 states with similar eligibility criteria.

Table 7. Access Parity for DDD EI Services

	2008 King County Population Birth to Four Years Old		2008 DDD Birth to Three Children Served		Ratio of % Children Served Compared to % Population
Race/Ethnicity	**All**	**% of Total**	**Number**	**% of Total**	**Parity**
Native Americans	1,134	1	23	1.1	1.09
Asian/Pacific Islander	16,389	14.6	292	13.9	0.96
African American	8,872	7.9	149	7	0.89
White	75,736	67.2	1,489	70	1.04
Two or More	10,520	9.3	38	2	0.21
Unreported			109	5	N/A
Total	112,651	100	2,100	100*	
Hispanic	14,131	12.5	333	15.9	1.26

*Adds up to 99% due to rounding

Several findings are of note:

- Percentages served and access parity numbers for small group populations (less than 30) should be interpreted with caution.
- Native American, Asian/Pacific Islander and White populations are accessing services at close to parity.
- African Americans are somewhat underserved, considering parity.
- Children identified as "Two or More" – those who are of mixed race/ethnicity – appear to be significantly underserved. However, the numbers for this group may be influenced by data reporting anomalies.

Outcome Analysis

There is no national research or data that leads the division to conclude that children of individual racial or ethnic populations in EI programs actually achieve higher or lower success rates.

The most recent county data available to DDD which shows children served who achieve age-appropriate developmental skills by the time a child exits their EI service program is summarized in Table 8 below.

Table 8. 2009 Comparison of Children Exiting Early Intervention Programs (Jan-June)

Total Children Exiting Services		Children Achieving Developmental Milestones at Exit	
Race/Ethnicity	**Number**	**Number**	**Percentage**
Native Americans	3	1	33
Asian/Pacific Islander	84	14	17
African American	43	6	14
Hispanic*	107	28	26
White	318	103	32
Two or More	83	21	25
Unreported	30	7	23
Total	668	180	27

*Hispanic group is included in Totals reported, as state's ITEIP database provides data in this fashion.

This table illustrates that of the 668 children exiting EI services programs countywide, 180 children (27 percent overall), were achieving age-appropriate milestones at exit.

Because of small ethnic/racial group numbers in Table 8, a parity analysis is not provided. As in the access data presented earlier, when breaking down this outcome data into racial/ethnic groups, most groups are small (<30 individuals). Also, of the 180 who achieved age appropriate milestones, 28 children (over 15 percent) were identified as belonging to the category "Two or More", or were shown in the database as "Unreported". Any attempted analysis of these two categories would be distorted by possible reporting anomalies.

Adding the non-White groups in Table 8 together into an aggregate "Of Color" group, 350 children Of Color exited services, and 77 children Of Color achieved age appropriate milestones at exit, or 22 percent of those achieving this milestone. While this is lower than White alone, because of the small sample sizes it is not considered to be statistically significant.

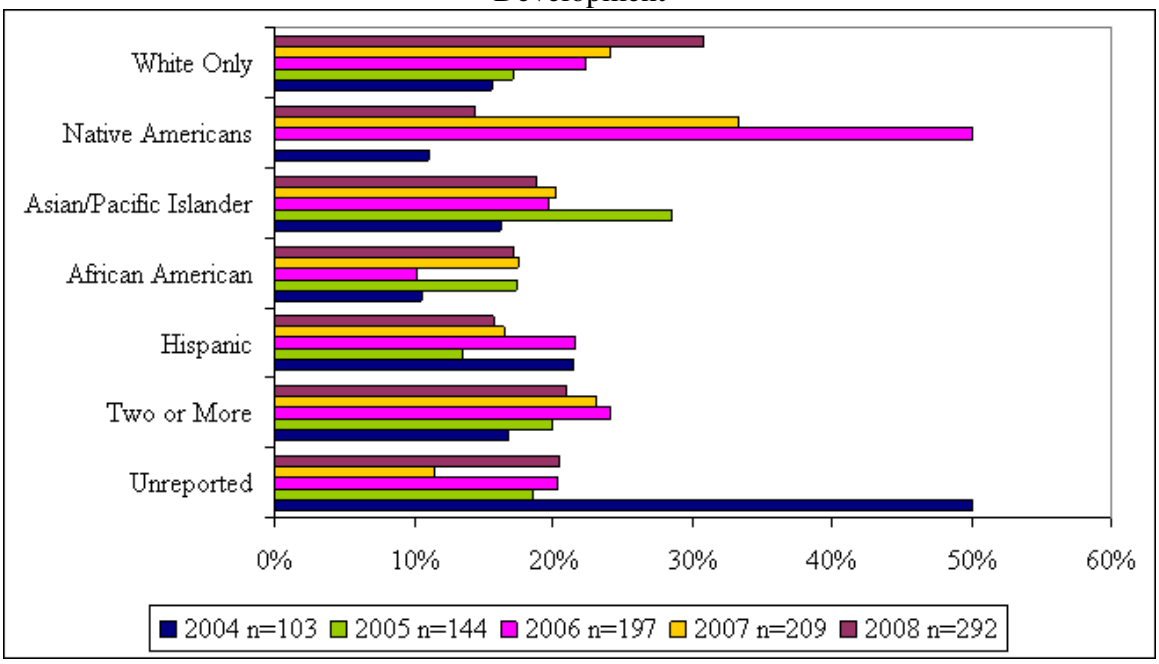
Taking a longer view, comparing the demographics of the population of children served by DDD's EI program through the years 2004 through 2008 it is difficult to make an analysis of those achieving developmental milestones by specific minority subgroups due to the very small sampling of numbers. However, it is evident that the numbers of children who acquire age-appropriate skills by program exit have significantly increased overall, which suggests that EI services are beneficial for all children, regardless of race/ethnicity. Table 9 shows the numbers of children with successful outcomes (achieving age-appropriate developmental milestones) as they exit their program of EI services.

Table 9. Number of Children Exiting Services Who Are Achieving Developmental Milestones

	2004	2005	2006	2007	2008
White	64	78	110	127	182
Of Color	39	66	87	82	110
Total	103	144	197	209	292
Detail of the Of Color					
Native American	1	0	3	2	1
Asian/Pacific Islander	11	26	24	21	33
African American	5	9	6	11	14
Hispanic	17	14	24	21	28
Two or More	4	12	20	22	25
Unreported	1	5	10	5	9

When analyzing successful outcomes by ethnic/racial subgroup for the years 2004 to 2008, very small sample sizes make it difficult to determine historical trends, with the exception of children who are White. See the data displayed in Chart 9 below..

Chart 9. Percent of Children Exiting Services Who Have Reached Age Appropriate Development



To improve upon historical program performance, DDD worked with an Early Intervention Action Team of the King County Interagency Coordinating Council (KCICC) and established targeted outreach strategies for those minority populations typically underserved, such as immigrant families for whom English is a second language and cultural barriers exist.

The KCICC identified three separate populations to be targeted in an EI pilot program involving a grass-roots approach for engagement of new families for EI services: Somali,

Vietnamese, and Hispanic. The division's work resulted in some key learnings about grass-roots, community-centered outreach to underserved minorities.

The DDD partnered with the SOAR[4] early childhood program to determine effective ways to reach out to these three different communities. The DDD and SOAR co-hosted "Community Conversations" in the native language of the three target populations, providing information about family social services, including EI. Through contacts made at the Community Conversations, fifteen bilingual, trusted individuals interested in becoming resources and community liaisons were identified and trained with materials DDD and SOAR developed. Each liaison was tasked to reach out to 20 families in their community – with an EI pilot program goal of 300 families contacted. Interest in the information available allowed the pilot to exceed its goal and actually contact nearly 1,000 families.

Current EI Pilot Program Progress Report

In the middle of the pilot, the SOAR program experienced significant restructuring. This disrupted some of the intended follow up with the families meant to determine effectiveness of services and overall client satisfaction with the EI pilot program approaches. The following are preliminary findings based upon SOAR interviews of community liaisons:

- Of 1,000 families contacted in 2008, 98 families requested additional information and support from the community liaisons.
- Forty-six of the 98 families with initial interest have lost contact or moved.
- Of the remaining 52 families, 29 have attempted to contact an EI or other social services provider.
- There are six remaining individuals committed to serving as community liaisons from the initial cadre of fifteen. These community liaisons have agreed to participate in a second phase of training and familiarization with the KCICC and its broader efforts in late 2009 and early 2010.

For 2009, despite many challenges, there has been a second wave of referrals:

- Hispanic outreach to 86 individual families, which has identified 54 families requesting social services information
- Vietnamese outreach to 72 families, which identified 32 families
- Somali outreach has broadened to include outreach presentations to these East African service/advocacy groups in the community:[5]

[4] *SOAR – helping kids reach for the sky* is a partnership housed originally at United Way of King County, and has been re-hosted to another agency. See http://www.childrenandyouth.org/ for more information.
[5] These organizations are very small and fluid – some are composed of a few extended families – and establishing proper approaches has been another piece of the learning that has occurred.

- Somali Bantu Association of Washington
- Horn of Africa Services
- Somali Community Services Coalition
- Somali Community Services of Seattle
- Somaliland Community Organization
- East African Community Services

The pilot program's goals were to learn how many of the families contacted by community liaisons in 2008 actually applied to the EI program, were enrolled in and received services, and were satisfied with their contact, enrollment and service experience (the ultimate outcome goal). SOAR will not have final interview results on how many families actually felt that they got their needs met until the end of the EI pilot program contract year (year end December 2009).

Lessons Learned

The DDD has learned that there are several barriers to keeping formal records on a grass roots community-centered program of this sort. Federal, state and agency data systems do not keep data that allow tracking of these underserved minority groups, for a reliable baseline or incremental changes. (This might mean that there will not be a way to empirically measure this pilot or any follow on efforts within these groups – at least in terms of achieving the larger target of 2.2 percent of families served in the county.) There were lessons learned about the suitability of different outreach materials, the desirable format for the community gatherings, and the training for community liaisons on how to establish and sustain appropriate relationships with interested families. The unique barriers encountered in these minority groups have been reported to include basic distrust of any government based program and cultural attitudes about developmental disabilities; both characteristics need to be carefully approached. For a developmental disabilities service system to approach members of these communities, more than bilingual written materials or translators are required. Trust, networking and personal contact are key concepts for success.

This type of program design requires a more formally planned sustaining structure. The 2009 program funding uncertainties and the disruption of re-hosting SOAR had a significant impact on the pilot. The EI pilot program depended heavily on community liaison volunteers and stability for a continuing stream of new, interested families and sustained family contacts.

The program disruptions may have lead to attrition that was an unknown in the beginning – in the number of community liaisons, the number of families available for follow up after initial expression of interest, as well as the number of families who have apparently proceeded to contact a service provider to determine suitability for entry into EI services. The best way to gather reliable information about a grass roots based program's effectiveness involves actual face to face follow up interviews with client families.

Recommendations

1. Conduct an evaluation at the end of the contract year 2009, confirming recommendations for 2010, including review of the following preliminary recommendations:

    - Identify the key elements of success. Determine a cost-effective mechanism to sustain this outreach approach. This work will be accomplished by DDD together with its partners at KCICC during first quarter 2010.
    - Investigate potential funding sources that are sustainable.
    - Determine qualifications and training of the community liaisons that may allow for financial reimbursement using existing EI funding sources (such as Family Resource Coordinators or interpreters).
    - Establish plan, with timelines, for securing the necessary training in order to access sustainable funding by 2011.

2. Develop recommendations regarding continued outreach and active follow up using the community liaisons within these three minority communities, and future expansion of outreach to other minority communities.
3. Work with EI providers during second and third quarter 2010 to determine methods to involve them in reporting and analysis of changes in enrollment for early intervention and prevention services for Somali, Vietnamese, and Hispanic families.
4. Build into future program planning appropriate allowance for a different style of reporting process for the EI pilot program that works better for these targeted subgroups - unique to their grass roots, personal relationship centered, community based, culturally and ethnically immersed environments.
5. Conduct networking/training events in first and second quarter 2010 for community based organizations serving unique cultural and linguistic communities and EI providers.
6. Conduct networking and training events in first and second quarter 2010 for community liaisons and community EI providers.
7. Establish a community liaison network, which EI providers may utilize in their work with non-English speaking families.
8. Ensure that EI pilot program future efforts align with priorities in DDD's new strategic plan, currently being developed for implementation July 2010.[6]

[6] This plan will supplant the current King County Plan for Developmental Disabilities Services (for the period July 1, 2005 through June 30, 2010). See http://www.kingcounty.gov/healthServices/DDD/plansAndPolicies/dddPlan.aspx for further information.

IV. Commitment III: Homelessness

The 2008 DCHS ESJI Commitment on Homelessness reads as follows:

Homelessness: Under guidance of the DCHS, King County will use Safe Harbors Homeless Management Information System (HMIS) data, program generated data and the Committee to End Homelessness (CEH) in King County Strategy Recommendations to link people of color, immigrants and refugees with homeless housing and services and understand barriers in accessing and succeeding in housing. The DCHS will use the understanding gained through such investigations to identify strategies that can be implemented through its programs that will increase access to and success in housing for those populations. The DCHS will seek to work with the CEH on addressing the issues.

Summary

This section of the report represents the continuation of the Community Services Division (CSD) commitments and participation in the department's ESJI efforts. The CSD is committed to understanding how race or ethnicity may impact client access to, and success in, the King County homeless services system. In 2009, the CSD evaluation unit conducted a two-part investigation. The first report from April 2009 presented initial findings on access to housing and homeless services by people of color who are homeless or at-risk of homelessness. This report is an investigation into the question "Are there different success rates in emergency shelter or transitional housing based upon the client's race or ethnicity?" The narrative that follows includes the summary and findings from the 2008 analysis of access, an update on access based on 2009 data and analysis of whether there are different outcomes in the homeless services system based upon a client's race or ethnicity. Clients served are compared to available data on those living below the federal poverty level, as those groups are most likely to be homeless or at risk of homelessness.

The good news is that from 2008 to 2009, CSD has improved measurement of race and ethnicity demographics of the clients served by CSD contractors serving the homeless. When a revised form was implemented during the reporting period, it was found that persons of color living below poverty levels access CSD homeless services in greater proportion than their White counterparts. An initial finding in spring 2009 (using the old 2008 form data) had appeared to show that Hispanics were not accessing most homeless services in numbers commensurate with their proportion of persons living below poverty. Subsequent analysis using the new collection form (and an outside validity check) found that people who are Hispanic are accessing all services proportionately.

The other good news is that extensive analysis of service outcomes of emergency shelters and transitional housing using the regional Safe Harbors HMIS demonstrated that people of color have no significantly different success rates compared to their White counterparts. This is especially true of families moving through the system. There was a single statistical anomaly that suggests that in 2008, Hispanic clients in family emergency shelter were not as successful in moving to permanent housing as other groups.

However, the outcomes analysis of sub-populations of specific race/ethnicity categories is limited by very small outcomes sample sizes – making staff hesitant to develop a solution until CSD can reliably verify or replicate this finding.

A finding has emerged that Asian/Pacific Islanders appear in the homeless system at a lower rate than would be expected, given the percent of Asian/Pacific Islanders living below poverty in King County. Discussions with service providers consistently suggest that Asian/Pacific Islanders may have a cultural, community bias to solving homelessness among themselves rather than engaging in formal homeless services.

Going forward in 2010 will require different strategies to understand whether there are any ESJI barriers in access or service outcomes. The data sources and collection methods used in 2009 have a number of significant limitations. There are four areas for action in 2010:

- Replicate the outcomes analysis with the new and expanded HMIS data to verify whether there is a problem with success rates of Hispanic families moving into permanent housing (January 2010).
- If the finding regarding Hispanic families is replicated, CSD will work with providers to develop more effective strategies for ensuring success for Hispanics in the family services system.
- Conduct interviews with stakeholders to determine if there are institutional barriers specific to Asian/Pacific Islanders accessing the services system (January - March 2010).
- Continue to improve quality and quantity of data collection and conduct ongoing monitoring of ESJI issues in CSD contracted homeless services (ongoing).

Ethnicity and Access to Homeless Services - 2008 Data Analysis

The first ESJI report on client access was presented in April 2009 and looked at access to services for persons who are homeless – with special attention to emergency shelter and transitional housing. The analysis used an aggregate of King County demographics reports for the first three quarters of 2008. The analysis took a look at the contractor reported race/ethnicity demographics using the 2008 King County demographics form and compared them with American Community Survey (ACS) data on poverty (where <FPL represents the number below Federal Poverty Level in King County). Table 10 which follows summarizes ACS data and CSD clients served by ethnicity/racial subgroup.

Table 10. Access to CSD Funded Homeless Services

Access to Services			People Served			
2005 – 2007 King County Population Estimate			CSD Homeless Services Three Quarters 2008			
<FPL			Compared to <FPL		Difference	Proportional Difference
Native American	Number	3,318	Number	806		
	%	1.9	%	3.5	+ 1.4	187
Asian/Pacific Islander	Number	24,399	Number	1,080		
	%	14	%	4.6	- 9.4	33
African American	Number	29,103	Number	5,841		
	%	16	%	25	+ 9	152
Two or More	Number	9,604	Number	4,681		
	%	5	%	20.1	+ 15.1	371
Other	Number	10,203	Number	159		
	%	6	%	0.7	- 5.3	12
White	Number	100,518	Number	10,730		
	%	57	%	46.1	- 11.9	81
Total	Number	172,9917	Number	23,297		
	%	100	%	100		
Hispanic	Number	24,235	Number	1,468		
	%	14	%	6.3	- 7.7	46

The analysis included secondary analysis on data from groups of services including: Basic Needs; Emergency Shelter; Prevention; Transitional Housing and Permanent Supported Housing. Findings included:

- In combined services statistics overall and individual service categories, people of color are served in significantly greater proportions than they appear in the ACS poverty data for King County.
- African Americans and Two or More Races are consistently higher proportionally in CSD services than in the ACS poverty data.
- Asian/Pacific Islanders are consistently underrepresented in services when compared to ACS poverty data for King County.
- Transitional housing appears to be the only service area that serves Hispanics at a level commensurate with their proportions in the ACS poverty data; in others they appear under represented (based upon the 2008 demographics form).

The April 2009 report concluded that persons of color accessed the service system in equal or greater proportion to persons who were White. The report concluded that the next step for the ESJI project should be an analysis of complete Safe Harbors HMIS data as to whether there is different success rates based upon race/ethnicity.

Update on Ethnicity/Race and Access to Homeless Services

In November 2009, CSD replicated the spring analysis using data from contracted agencies' 2009 King County demographic reports. The analysis used aggregated

demographic data for the first three quarters of 2009 as reflected in Table 10 on the following page.

Change in Race and Ethnicity Data Collection Categories

King County CSD demographics collection form was changed in 2009 to mirror the U.S. Census Bureau's race and ethnicity structure. Prior to 2009, Hispanic was included as a race category in CSD's demographic reporting. Many Hispanics were masked in the Two or More Races or Other race categories. It was noted during the ESJI Initiative review of the 2008 data that this misalignment to U.S. Census data made comparisons to community data questionable.

Findings from updated analysis (reflected in Table 10) include:

- Persons of Color continue to access the 103 CSD contracted homeless service projects in greater proportion than King County persons below the FPL (approximately 57 percent of clients served are of a race other than White, versus 43 percent of King County persons below FPL).
- Now that the new form is implemented, the data shows that Hispanics are served commensurately with their portion of the populations in need of CSD programs.
- Data continues to confirm that Asian/Pacific Islanders appear to be under-represented in the service populations.

Recommendations from the update effort include:

- Continue to monitor ESJI access data on a regular basis.
- Conduct an interview investigation with service providers to investigate the question of why it appears Asian/Pacific Islanders do not seek homeless services in King County. Determine if this is a problem that warrants King County homeless services developing new or different outreach strategies to Asian/Pacific Islander populations.

Table 11. Access to CSD Funded Homeless Services

Access to Services			People Served			
2007 – 2009 King County Population Estimate			CSD Homeless Services 3 Quarters 2009			
<FPL			Compared to <FPL		Difference	Proportional Difference
Native American	Number	3,224	Number	1,029		
	%	1.9	%	3.8	+ 1.9	200
Asian/Pacific Islander	Number	24,498	Number	1,462		
	%	14.2	%	5.4	- 8.8	38
African American	Number	28,784	Number	6,031		
	%	16.6	%	22.1	+ 5.5	133
Two or More	Number	8,758	Number	6,187		
	%	5.1	%	22.7	+ 17.6	445
Other	Number	8,652	Number	800		
	%	5.0	%	2.9	- 2.1	58
White	Number	99,075	Number	11,806		
	%	57.3	%	43.2	- 14.1	75
Total	Number	172,9917	Number	27,315		
	%	100	%	100		
Hispanic	Number	23,757	Number	6,016		
	%	13.7	%	22	+ 8.3	161

Evaluation of Success Rates based upon Race or Ethnicity

This effort looks at whether the effectiveness/success rates of emergency shelter and transitional housing programs are different based on whether a client is a person of color. In other words "Do persons of color succeed in comparable rates as persons who are white?" Then, "Are there significantly different success rates between specific race/ethnicities?" Program "effectiveness/success" is defined as the client of emergency shelter moved into transitional or permanent housing; or the client of transitional housing moved into permanent housing (thus effectively ending their homelessness).

The analysis was conducted using de-identified client data from the HMIS, provided by Safe Harbors' staff to CSD. The CSD evaluation staff developed a data set of 10,870 unduplicated emergency shelter and transitional housing clients for which race/ethnicity was clarified and categorized for analysis. This Safe Harbors HMIS data set provided exit data on 7,225 clients leaving shelter and transitional housing services in 2008.

Clients were identified as having met successful outcome criteria (or not) by the use of three HMIS data elements (reason for leaving, move destination and types of housing moved to). Four cohorts were created for outcomes analysis based upon type of service and household type, specifically clients served by: 1) Family Emergency Shelters, 2) Family Transitional Housing, 3) Single Adult Emergency Shelters, and 4) Single Adult Transitional Housing.

Using these combined criteria, the cohorts (as shown in Table 12 following) for analysis are:

Family Emergency Shelter:	742 persons
Family Transitional Housing:	165 persons
Singles Emergency Shelter:	5,716 persons
Singles Transitional Housing:	602 persons

Table 12. Analysis Cohorts and Outcome Categories

		Success	Non-success	Insufficient time	Destination Unknown-Disappeared	Total
Family Emergency Shelters	Number	159	429	154	0	742
	%	21.4	57.8	20.8	0	100
Family Transitional Housing	Number	83	74	8	0	165
	%	50.3	44.8	4.8	0	100
Single Emergency Shelter	Number	122	173	896	4,525	5,716
	%	2.1	3	15.7	79.2	100
Single Transitional Housing	Number	167	284	151	0	602
	%	27.7	47.2	25.1	0	100
Total	Number	531	960	1,209	4,525	7,225
	%	7.3	13.3	16.7	62.6	100

Analysis and Observations – the Effect of Race on Success

Family Emergency Shelter: Of the total 742 individuals of the exit cohort, 49 percent completed the program and five percent left early for a housing opportunity. However, only a small number of the records indicated "Completed Program" and also designated a move destination or a housing type. Reference Table 13 below.

Table 13. Family Emergency Shelter Outcomes

		Success	Non-success	Total
People of Color	Number	120	312	432
	%	27.8	72.2	100
White	Number	39	117	156
	%	25	75	100
Total	Number	159	429	588
	%	27	73	100

The success rates for the total cohort were 27 percent of clients (159) moving into Permanent or Transitional Housing from Family Emergency Shelter. Persons of color had a 27.8 percent success rate and persons who are White had a 25 percent success rate. There was no significant statistical difference between persons of color and those who are White.

The analysis broke down race/ethnicity into census categories and assessed comparative difference. Chi Square analysis indicated that there was a statistically significant difference between race codes success. It would appear that Hispanics had a significantly lower success rate than any other category (that had enough records).

Hispanics had a very low success rate, at 5.3 percent. The sample size was small at 38 persons, which would suggest that this specific finding should be replicated for verification purposes when greater amounts of data are available in 2010. Table 14 below illustrates the data.

Table 14. Family Emergency Shelter Outcomes

Success Rates for Specific Ethnicity/Race Categories		Success	Non-success	Total
Native American	Number	9	13	22
	%	40.9	59.1	100
Asian	Number		1	1
	%	0	100	100
African American	Number	76	205	281
	%	27	73	100
Hispanic	Number	2	36	38
	%	5.3	94.7	100
Pacific Islander	Number	9	8	17
	%	52.9	47.1	100
Two or More	Number	24	49	73
	%	32.9	67.1	100
White	Number	39	117	156
	%	25	75	100
Total	Number	159	429	588
	%	27	73	100

African Americans had a 27 percent success rate (281 individuals). Those clients reporting two or more races had a 32.9 percent success rate (73 individuals).

With further breakdown, many groups were too small to be considered for analysis, as their sample sizes were below 30 persons (for example, Native Americans at 22 persons, and only a single Asian American).

Family Transitional Shelter: There were 165 unique individuals in this cohort. Of these, 157 individuals met sufficient length of stay length criteria (at least 30 days). Of the 165 individuals, 122 either completed the program or left early for a housing opportunity. Of the "non-success" rating, 27 of those completing the program were designated non-successful because the provider did not know destination or type of housing. The data in Table 15 which follows summarizes this.

Table 15. Family Transitional Housing Outcomes

Success Rates Comparison		Success	Non-success	Total
People of Color	Number	76	55	131
	%	58	42	100
White	Number	7	19	26
	%	26.9	73.1	100
Total	Number	83	74	157
	%	52.9	47.1	100

The overall designated success rate for the Family Transitional program was higher than other cohorts. There were 83 persons assigned success (52.9 percent). Persons of color had a 58 percent success rate. Interestingly enough, persons who are White had a very low success rate (26.9 percent).

While statistically significant, the sample size of persons who are White was very small, at 16 percent of the total cohort and only 26 persons. This will need further review in the future to see if the differences remain in a larger sample from 2009 HMIS data. Table 16 shows successful outcomes for family transitional housing.

Table 16. Family Transitional Housing Outcomes

Success Rates for Specific Ethnicity/Race Categories		Success	Non-success	Total
Native American	Number	3		3
	%	100	0	100
Asian	Number		1	1
	%	0	100	100
African American	Number	47	24	71
	%	66.2	33.8	100
Hispanic	Number	7	10	17
	%	41.2	58.8	100
Pacific Islander	Number	8	5	13
	%	61.5	38.5	100
Two or more races	Number	11	15	26
	%	42.3	57.7	100
White	Number	7	19	26
	%	26.9	73.1	100
Total	Number	83	74	157
	%	52.9	47.1	100

Analyzing the data by census categories, African Americans had a 66.2 percent success rate (number of clients equaled 71). Hispanics had a consistent success rate but a small total number. There was no statistically significant difference based upon race/ethnicity. As with the Family Emergency Shelter cohort, with the further breakdown many racial groups were too small to be considered for analysis, as their sample sizes were below 30 persons.

Singles Emergency Shelter: The project analysts determined that there were not enough exits that met the success criteria to conduct credible analysis for this cohort. Although over 4,500 clients were designated as having "completed" the shelter program, in very few cases was there an identification of where the client left or known housing status. Only 5.1 percent of all clients had enough information to determine whether they had a "successful exit" or not.

Singles Transitional Shelter: The analysis cohort had 602 unique individuals. Of these, 151 individuals did not meet sufficient length of stay criteria (at least 30 days in the program). Thus, 25 percent of the Single Transitional Housing cohort did not stay even a single month. This raises a question for future analysis as to who is entering single transitional housing and whether there is racial disparity among those leaving transitional housing early. See Table 17 below for the summary data.

Table 17. Singles Transitional Housing Outcomes

Success Rates Comparison		**Success**	**Non-success**	**Total**
People of Color	Number	69	133	202
	%	34.2	65.8	100
White	Number	98	151	249
	%	39.4	60.6	100
Total	Number	167	284	451
	%	37	63	100

Of the 451 individuals, 167 met the success criteria (37 percent). There was no statistically significant difference as to whether a client was a person Of Color (34.2 percent success) or White (39.4 percent). Table 18 following shows outcomes for singles transitional housing.

Table 18. Singles Transitional Housing Outcomes

Success Rates based upon Specific Race/Ethnicity Category		**Success**	**Non-success**	**Total**
Native American	Number	5	10	15
	%	33.3	66.7	100
Asian	Number	3	9	12
	%	25	75	100
African American	Number	51	92	143
	%	35.7	64.3	100
Hispanic	Number	6	17	23
	%	26.1	73.9	100
Pacific Islander	Number	1	3	4
	%	25	75	100
Two or More	Number	3	2	5
	%	60	40	100
White	Number	98	151	249
	%	39.4	60.6	100
Total	Number	167	284	451
	%	37	63	100

Further breaking down race into census categories, African Americans had a 35.7 percent success rate (51 of 143). In this analysis Hispanics, Native Americans, and Pacific Islanders had slightly lower success rates. However, the total numbers are too small for definitive analysis. Over 42 percent of the "non-success" clients (121) were assigned the rating where the provider had identified them as completing the program but did not know the type of housing they moved to.

Overall Findings on the Impact of Race on Success Rates

- People of color in general have the same level of success in the regional homeless services system as do those who are White.
- There were no statistically significant differences for successful service outcomes for combined people of color versus White in Family Emergency Shelter, Family Transitional Housing, and Singles Transitional Housing.
- Statistical analysis of success by specific race/ethnicity categories showed Hispanic family clients as less likely either to move to transitional housing or to permanent housing from Family Emergency Shelter than any other group.
- The numbers of Asian, Native Americans, or Pacific Islander clients in each cohort with complete exit data were too small to conduct valid analysis for these subgroups.
- There was not enough complete exit data on Singles Emergency Shelter clients to conduct reliable outcomes analysis (only 295 of 5,716 these clients had an exit date, identified "Reason for Leaving" and identified "Type of Housing Moved To").

<u>Recommendations</u>

Recommendations address primarily efforts to improve CSD's understanding of ethnicity and successful outcomes:

1. With improved data collection and greater provider participation, evaluators should verify the finding regarding low success rates for Hispanic persons in the family shelter system in January 2010.
2. If the above finding is replicated, CSD will work with providers to develop more effective strategies for ensuring success for Hispanics in the family services system.
3. In 2010, the county should review success data for the clients who are Asian, Native American, and Pacific Islander if numbers increase to support reliable analysis.
4. In 2010, prevention programs should be included in the race/ethnicity success analysis, as 2009 data allows.
5. King County needs to ensure consistent data practices in the new Safe Harbors HMIS and develop further understanding for improving data on success rates, especially reducing the number of unknown housing results in the exit data from Single Adult Emergency Shelters.

V. Conclusions and Recommendations Regarding Access Outcomes

Our updates on minority access to services led to some key findings. Access by persons of racial/ethnic minorities to services does appear to be an issue in some cases for mental illness and chemical dependency treatment programs, early intervention and prevention programs for children, and services to the homeless.

Earlier analysis had presented evaluation staff with a preliminary finding that there might be an issue regarding access to homeless services for Hispanics. This update report, using more refined tools, allowed staff to see that there was no access disparity for this population.

Asian/Pacific Islander populations seem to represent a general exception. The numbers of Asians/Pacific Islanders accessing any one of the service types evaluated in this report are small enough to inhibit detailed analysis; this may be a result of language barriers, distrust of government services, and cultural biases that need to be overcome by outreach efforts. Outreach to this underserved subgroup entails significant challenges in that there are over 40 different identifiable nationalities in this broad category. Available data systems do not provide ways to readily pinpoint these populations to evaluate the results of outreach efforts.

The number of Native American and African American families using Early Intervention and Prevention Services is also small. Additional outreach efforts for some of the underserved minority subgroups (Somali, Vietnamese) that have been undertaken by DDD may improve their access to EI services, though it may be difficult to identify the results of such outreach from conventional sources.

Native Americans are among the most frequent users of the sobering services provided by the Dutch Shisler Sobering Support Center (DSSSC), indicating significant unmet needs within this subgroup for chemical dependency treatment and supports that promote sustained recovery.

Analysis of successful outcomes for minority groups also resulted in some conclusions. For chemical dependency treatment services, definite improvement trends were found in treatment completion rates for both African American youth and adults.

There was data supporting an initial finding that Hispanic families making use of the homeless services system experience a somewhat lower success rate than other racial/ethnic subgroups; verification of that finding using future, more complete Safe Harbors HMIS data is needed. If this finding is verified, an increased emphasis on culturally appropriate supports and services may be warranted.

Development and implementation of regional strategic plans for county services (e.g. the Ten-Year Plan to End Homelessness, the Veterans and Human Services Levy, the Mental Illness and Drug Dependency Action Plan, Criminal Justice Initiatives, King County Plan for Developmental Disabilities Services 2010 - 2013) are essential to achieve significant gains in King County's efforts regarding Equity and Social Justice for all residents.

Appendix A

Data Notes for Commitment I: Mental Health and Substance Abuse

The treatment completion calculations exclude admissions with certain discharge reasons that cannot be categorized as either a successful or unsuccessful outcome. Admissions that have not yet ended and admissions with a discharge reason of "Completed treatment" are included in the numerator. Those admissions and admissions that have ended with the following reasons are included in the denominator: no contact/aborted treatment, not amenable to treatment, rule violation and withdrew against program advice. Discharges for the following reasons are excluded from the calculation of treatment completion rate: client died, funds exhausted, inappropriate admission, incarcerated, moved, transferred to different facility, withdrew with program advice, administrative closure and other.

The treatment completion rates shown cannot be compared to rates MHCADSD reports for overall performance measures for the following reasons:

1. The data shown here use a different age split (under 24; 24 and older) than that used for most performance measures (under 18; 18 and older)
2. Data shown here are grouped by the admission year, rather than the discharge year, and those people who were admitted in a given year and have not yet been discharged are included
3. Performance measures are for all ethnic groups combined. Because the two groups used that comprise the whole population (White alone and "Of Color") are not equal in size the overall rate cannot be determined from the data presented here, which are only the total numbers of admissions and the completion and retention percentages

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Sources:

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3. Speller, H., *Asian Americans and Mental Health: Cultural Barriers to Effective Treatment,* Elements, Spring 2005 http://www.bc.edu/research/elements/issues/2005s/elements-spring2005-article8.pdf